
HOUSE BILL 2660

State of Washington

60th Legislature

2008 Regular Session

By Representatives Green and Morrell

Read first time 01/15/08. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to primary medical eye care; reenacting and
2 amending RCW 48.43.005; adding new sections to chapter 48.43 RCW; and
3 creating a new section.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** The legislature finds and declares that
6 there is a paramount concern that the right of the people to obtain
7 access to health care in all its facets should be preserved and
8 enhanced. The legislature also finds that the establishment of a
9 medical home is an effective way to improve quality of care and reduce
10 unnecessary administrative costs in the delivery of care. The
11 legislature further finds that the unique characteristics of eye care
12 and the structure of insurance coverage relating to medical eye care
13 and vision only services create confusion among enrollees of health
14 plans and create inefficiencies in the delivery of medical eye care,
15 and that creating a primary care medical home relationship for eye care
16 patients will improve the quality of care and reduce the cost of eye
17 care. It is the intent of the legislature to eliminate unnecessary
18 burdens faced by patients needing medical eye care services. It is,

1 therefore, declared to be in the public interest that health plans
2 covering primary medical eye care conform to certain minimum
3 requirements.

4 **Sec. 2.** RCW 48.43.005 and 2007 c 296 s 1 and 2007 c 259 s 32 are
5 each reenacted and amended to read as follows:

6 Unless otherwise specifically provided, the definitions in this
7 section apply throughout this chapter.

8 (1) "Adjusted community rate" means the rating method used to
9 establish the premium for health plans adjusted to reflect actuarially
10 demonstrated differences in utilization or cost attributable to
11 geographic region, age, family size, and use of wellness activities.

12 (2) "Basic health plan" means the plan described under chapter
13 70.47 RCW, as revised from time to time.

14 (3) "Basic health plan model plan" means a health plan as required
15 in RCW 70.47.060(2)(e).

16 (4) "Basic health plan services" means that schedule of covered
17 health services, including the description of how those benefits are to
18 be administered, that are required to be delivered to an enrollee under
19 the basic health plan, as revised from time to time.

20 (5) "Catastrophic health plan" means:

21 (a) In the case of a contract, agreement, or policy covering a
22 single enrollee, a health benefit plan requiring a calendar year
23 deductible of, at a minimum, one thousand seven hundred fifty dollars
24 and an annual out-of-pocket expense required to be paid under the plan
25 (other than for premiums) for covered benefits of at least three
26 thousand five hundred dollars, both amounts to be adjusted annually by
27 the insurance commissioner; and

28 (b) In the case of a contract, agreement, or policy covering more
29 than one enrollee, a health benefit plan requiring a calendar year
30 deductible of, at a minimum, three thousand five hundred dollars and an
31 annual out-of-pocket expense required to be paid under the plan (other
32 than for premiums) for covered benefits of at least six thousand
33 dollars, both amounts to be adjusted annually by the insurance
34 commissioner; or

35 (c) Any health benefit plan that provides benefits for hospital
36 inpatient and outpatient services, professional and prescription drugs

1 provided in conjunction with such hospital inpatient and outpatient
2 services, and excludes or substantially limits outpatient physician
3 services and those services usually provided in an office setting.

4 In July 2008, and in each July thereafter, the insurance
5 commissioner shall adjust the minimum deductible and out-of-pocket
6 expense required for a plan to qualify as a catastrophic plan to
7 reflect the percentage change in the consumer price index for medical
8 care for a preceding twelve months, as determined by the United States
9 department of labor. The adjusted amount shall apply on the following
10 January 1st.

11 (6) "Certification" means a determination by a review organization
12 that an admission, extension of stay, or other health care service or
13 procedure has been reviewed and, based on the information provided,
14 meets the clinical requirements for medical necessity, appropriateness,
15 level of care, or effectiveness under the auspices of the applicable
16 health benefit plan.

17 (7) "Concurrent review" means utilization review conducted during
18 a patient's hospital stay or course of treatment.

19 (8) "Covered person" or "enrollee" means a person covered by a
20 health plan including an enrollee, subscriber, policyholder,
21 beneficiary of a group plan, or individual covered by any other health
22 plan.

23 (9) "Dependent" means, at a minimum, the enrollee's legal spouse
24 and unmarried dependent children who qualify for coverage under the
25 enrollee's health benefit plan.

26 (10) "Eligible employee" means an employee who works on a full-time
27 basis with a normal work week of thirty or more hours. The term
28 includes a self-employed individual, including a sole proprietor, a
29 partner of a partnership, and may include an independent contractor, if
30 the self-employed individual, sole proprietor, partner, or independent
31 contractor is included as an employee under a health benefit plan of a
32 small employer, but does not work less than thirty hours per week and
33 derives at least seventy-five percent of his or her income from a trade
34 or business through which he or she has attempted to earn taxable
35 income and for which he or she has filed the appropriate internal
36 revenue service form. Persons covered under a health benefit plan
37 pursuant to the consolidated omnibus budget reconciliation act of 1986

1 shall not be considered eligible employees for purposes of minimum
2 participation requirements of chapter 265, Laws of 1995.

3 (11) "Emergency medical condition" means the emergent and acute
4 onset of a symptom or symptoms, including severe pain, that would lead
5 a prudent layperson acting reasonably to believe that a health
6 condition exists that requires immediate medical attention, if failure
7 to provide medical attention would result in serious impairment to
8 bodily functions or serious dysfunction of a bodily organ or part, or
9 would place the person's health in serious jeopardy.

10 (12) "Emergency services" means otherwise covered health care
11 services medically necessary to evaluate and treat an emergency medical
12 condition, provided in a hospital emergency department.

13 (13) "Enrollee point-of-service cost-sharing" means amounts paid to
14 health carriers directly providing services, health care providers, or
15 health care facilities by enrollees and may include copayments,
16 coinsurance, or deductibles.

17 (14) "Grievance" means a written complaint submitted by or on
18 behalf of a covered person regarding: (a) Denial of payment for
19 medical services or nonprovision of medical services included in the
20 covered person's health benefit plan, or (b) service delivery issues
21 other than denial of payment for medical services or nonprovision of
22 medical services, including dissatisfaction with medical care, waiting
23 time for medical services, provider or staff attitude or demeanor, or
24 dissatisfaction with service provided by the health carrier.

25 (15) "Health care facility" or "facility" means hospices licensed
26 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
27 rural health care facilities as defined in RCW 70.175.020, psychiatric
28 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
29 under chapter 18.51 RCW, community mental health centers licensed under
30 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
31 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
32 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
33 facilities licensed under chapter 70.96A RCW, and home health agencies
34 licensed under chapter 70.127 RCW, and includes such facilities if
35 owned and operated by a political subdivision or instrumentality of the
36 state and such other facilities as required by federal law and
37 implementing regulations.

38 (16) "Health care provider" or "provider" means:

1 (a) A person regulated under Title 18 or chapter 70.127 RCW, to
2 practice health or health-related services or otherwise practicing
3 health care services in this state consistent with state law; or

4 (b) An employee or agent of a person described in (a) of this
5 subsection, acting in the course and scope of his or her employment.

6 (17) "Health care service" means that service offered or provided
7 by health care facilities and health care providers relating to the
8 prevention, cure, or treatment of illness, injury, or disease.

9 (18) "Health carrier" or "carrier" means a disability insurer
10 regulated under chapter 48.20 or 48.21 RCW, a health care service
11 contractor as defined in RCW 48.44.010, or a health maintenance
12 organization as defined in RCW 48.46.020.

13 (19) "Health plan" or "health benefit plan" means any policy,
14 contract, or agreement offered by a health carrier to provide, arrange,
15 reimburse, or pay for health care services except the following:

16 (a) Long-term care insurance governed by chapter 48.84 RCW;

17 (b) Medicare supplemental health insurance governed by chapter
18 48.66 RCW;

19 (c) Coverage supplemental to the coverage provided under chapter
20 55, Title 10, United States Code;

21 (d) Limited health care services offered by limited health care
22 service contractors in accordance with RCW 48.44.035;

23 (e) Disability income;

24 (f) Coverage incidental to a property/casualty liability insurance
25 policy such as automobile personal injury protection coverage and
26 homeowner guest medical;

27 (g) Workers' compensation coverage;

28 (h) Accident only coverage;

29 (i) Specified disease or illness-triggered fixed payment insurance,
30 hospital confinement fixed payment insurance, or other fixed payment
31 insurance offered as an independent, noncoordinated benefit;

32 (j) Employer-sponsored self-funded health plans;

33 (k) Dental only and vision only coverage; and

34 (l) Plans deemed by the insurance commissioner to have a short-term
35 limited purpose or duration, or to be a student-only plan that is
36 guaranteed renewable while the covered person is enrolled as a regular
37 full-time undergraduate or graduate student at an accredited higher

1 education institution, after a written request for such classification
2 by the carrier and subsequent written approval by the insurance
3 commissioner.

4 (20) "Material modification" means a change in the actuarial value
5 of the health plan as modified of more than five percent but less than
6 fifteen percent.

7 (21) "Preexisting condition" means any medical condition, illness,
8 or injury that existed any time prior to the effective date of
9 coverage.

10 (22) "Premium" means all sums charged, received, or deposited by a
11 health carrier as consideration for a health plan or the continuance of
12 a health plan. Any assessment or any "membership," "policy,"
13 "contract," "service," or similar fee or charge made by a health
14 carrier in consideration for a health plan is deemed part of the
15 premium. "Premium" shall not include amounts paid as enrollee point-
16 of-service cost-sharing.

17 (23) "Primary medical eye care" means all health care services
18 within the scope of practice of optometry as defined in RCW 18.53.010,
19 whether provided or performed by a provider licensed under chapter
20 18.53, 18.57, or 18.71 RCW.

21 (24) "Review organization" means a disability insurer regulated
22 under chapter 48.20 or 48.21 RCW, health care service contractor as
23 defined in RCW 48.44.010, or health maintenance organization as defined
24 in RCW 48.46.020, and entities affiliated with, under contract with, or
25 acting on behalf of a health carrier to perform a utilization review.

26 ((+24)) (25) "Small employer" or "small group" means any person,
27 firm, corporation, partnership, association, political subdivision,
28 sole proprietor, or self-employed individual that is actively engaged
29 in business that, on at least fifty percent of its working days during
30 the preceding calendar quarter, employed at least two but no more than
31 fifty eligible employees, with a normal work week of thirty or more
32 hours, the majority of whom were employed within this state, and is not
33 formed primarily for purposes of buying health insurance and in which
34 a bona fide employer-employee relationship exists. In determining the
35 number of eligible employees, companies that are affiliated companies,
36 or that are eligible to file a combined tax return for purposes of
37 taxation by this state, shall be considered an employer. Subsequent to
38 the issuance of a health plan to a small employer and for the purpose

1 of determining eligibility, the size of a small employer shall be
2 determined annually. Except as otherwise specifically provided, a
3 small employer shall continue to be considered a small employer until
4 the plan anniversary following the date the small employer no longer
5 meets the requirements of this definition. A self-employed individual
6 or sole proprietor must derive at least seventy-five percent of his or
7 her income from a trade or business through which the individual or
8 sole proprietor has attempted to earn taxable income and for which he
9 or she has filed the appropriate internal revenue service form 1040,
10 schedule C or F, for the previous taxable year except for a self-
11 employed individual or sole proprietor in an agricultural trade or
12 business, who must derive at least fifty-one percent of his or her
13 income from the trade or business through which the individual or sole
14 proprietor has attempted to earn taxable income and for which he or she
15 has filed the appropriate internal revenue service form 1040, for the
16 previous taxable year. A self-employed individual or sole proprietor
17 who is covered as a group of one on the day prior to June 10, 2004,
18 shall also be considered a "small employer" to the extent that
19 individual or group of one is entitled to have his or her coverage
20 renewed as provided in RCW 48.43.035(6).

21 ~~((+25+))~~ (26) "Subcontract" means any agreement between a health
22 carrier and another entity whereby health care services are provided to
23 the health carrier's enrollees through providers contracted directly
24 with such other entity.

25 (27) "Utilization review" means the prospective, concurrent, or
26 retrospective assessment of the necessity and appropriateness of the
27 allocation of health care resources and services of a provider or
28 facility, given or proposed to be given to an enrollee or group of
29 enrollees.

30 ~~((+26+))~~ (28) "Vision only coverage" means coverage that is limited
31 to periodic eye examinations, determining refractive error, prescribing
32 corrective lenses, and dispensing corrective lenses.

33 (29) "Wellness activity" means an explicit program of an activity
34 consistent with department of health guidelines, such as, smoking
35 cessation, injury and accident prevention, reduction of alcohol misuse,
36 appropriate weight reduction, exercise, automobile and motorcycle
37 safety, blood cholesterol reduction, and nutrition education for the

1 purpose of improving enrollee health status and reducing health service
2 costs.

3 NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW
4 to read as follows:

5 (1) A health plan that includes primary medical eye care shall
6 provide for enrollees a complete list of health care providers
7 contracted with the health plan, either directly or through a
8 subcontract, to provide primary medical eye care to enrollees, and all
9 such providers shall be available to all enrollees.

10 (2) A health plan that includes primary medical eye care shall
11 permit enrollees to work with any health care provider contracted with
12 the health plan, either directly or through a subcontract, to provide
13 primary medical eye care to enrollees, on the same terms as the
14 enrollee works with his or her primary care physician.

15 (3) A referral for specialty eye care services made by a health
16 care provider contracted with the health plan, either directly or
17 through a subcontract, to provide primary medical eye care to
18 enrollees, shall be deemed equivalent to a referral by a primary care
19 physician for all purposes, including enrollee point-of-service
20 cost-sharing calculations.

21 (4) Enrollee point-of-service cost-sharing requirements for primary
22 medical eye care shall be no greater than enrollee point-of-service
23 cost-sharing requirements for services provided by a designated primary
24 care physician.

25 (5) Health care providers contracted with a health carrier, either
26 directly or through a subcontract, to provide primary medical eye care
27 to enrollees, shall be limited in their ability to receive compensation
28 for health care services only to the extent that those health care
29 services are not covered by a health plan or are outside the legal
30 scope of practice of the health care provider.

31 (6) A health carrier shall not discriminate in any way between
32 health care providers licensed to perform primary medical eye care
33 services included in any health plan offered by the health carrier
34 solely or predominantly because of the type of license held by a health
35 care provider.

1 NEW SECTION. **Sec. 4.** A new section is added to chapter 48.43 RCW
2 to read as follows:

3 (1) This act does not require and shall not be construed to require
4 any health plan to include primary medical eye care.

5 (2) Health carriers that provide coverage for primary medical eye
6 care may continue to establish and apply selection criteria and
7 utilization protocols for health care providers and credentialing
8 criteria used in the selection of providers, as long as they do not
9 discriminate against any group of eye care providers solely or
10 predominantly because of the type of license held by those providers.

11 (3) Nothing in this chapter shall be construed to expand the scope
12 of practice for any eye care provider.

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